FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044263

Facility Name: GILMAN NURSING PAVILION

Address: 1390 SOUTH CRESCENT ST, BOX 307 (Number) GILMAN (City) 60938 (Zip Code)

County: IROQUOIS

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-4264598

Date of Initial License for Current Owners: 01/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) MARSHALL MAUER

(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,013	5,078	3,997	13,088	8
9	SNF/PED					9
10	ICF	10,940	4,820		15,760	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,953	9,898	3,997	28,848	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.83%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 7 and days of care provided 3,644

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	176,904	13,624	6,024	196,552		196,552		196,552			1
2	Food Purchase		147,449		147,449	(21,170)	126,279	(2,076)	124,203			2
3	Housekeeping	117,795	21,988		139,783		139,783		139,783			3
4	Laundry	27,200	18,850	8,386	54,436		54,436		54,436			4
5	Heat and Other Utilities			80,236	80,236		80,236	770	81,006			5
6	Maintenance	30,177	24,334	18,989	73,500		73,500	6,489	79,989			6
7	Other (specify):*			6,051	6,051		6,051	418	6,469			7
8	**TOTAL General Services**	352,076	226,245	119,686	698,007	(21,170)	676,837	5,601	682,438			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	1,217,094	48,768	4,020	1,269,882		1,269,882	(1,258)	1,268,624			10
10a	Therapy	59,914	150	2,389	62,453		62,453		62,453			10a
11	Activities	94,992	7,240		102,232		102,232		102,232			11
12	Social Services	49,974		1,464	51,438		51,438		51,438			12
13	CNA Training			500	500		500		500			13
14	Program Transportation			183	183		183		183			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,421,974	56,158	9,756	1,487,888		1,487,888	(1,258)	1,486,630			16
	C. General Administration											
17	Administrative	72,869		28,000	100,869		100,869	52,445	153,314			17
18	Directors Fees											18
19	Professional Services			34,800	34,800		34,800	1,601	36,401			19
20	Dues, Fees, Subscriptions & Promotions			39,484	39,484		39,484	(30,890)	8,594			20
21	Clerical & General Office Expenses	32,661	17,287	262,110	312,058		312,058	(198,108)	113,950			21
22	Employee Benefits & Payroll Taxes			259,664	259,664	21,170	280,834		280,834			22
23	Inservice Training & Education			2,911	2,911		2,911	(190)	2,721			23
24	Travel and Seminar							64	64			24
25	Other Admin. Staff Transportation			14,569	14,569		14,569	1,024	15,593			25
26	Insurance-Prop.Liab.Malpractice			62,047	62,047		62,047	1,301	63,348			26
27	Other (specify):*			447	447		447	23,389	23,836			27
28	**TOTAL General Administration**	105,530	17,287	704,032	826,849	21,170	848,019	(149,364)	698,655			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,879,580	299,690	833,474	3,012,744		3,012,744	(145,021)	2,867,723			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: GILMAN NURSING PAVILION **#0044263** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,280	
	REPAIRS & MAINTENANCE		744	
			0	6,024
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,262	
	CONTRACTED LAUNDRY SERVICES		7,124	8,386
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		4,777	
	ELECTRICITY		53,735	
	WATER		21,724	
	CABLE TV - LOBBY		0	
			0	80,236
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,645	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,575	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,084	
	FIRE SERVICE		0	
	CONTRACTED BUILDING MAINTENANCE		10,685	
			0	
			0	18,989
7	**OTHER**			
	SCAVENGER		6,051	
	SECURITY SERVICE		0	6,051
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,200	1,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	4,020	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	4,020
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,969	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	405	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	15	2,389
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	1,464	
			0	1,464
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	500	500

Facility Name & ID Number GILMAN NURSING PAVILION **#0044263** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		183	183
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	28,000	28,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	2,443	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	32,357	
			0	34,800
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	28,267	
	EMPLOYEE WANT ADS	XIX F	1,239	
	CONTRIBUTIONS	VI 20 XIX F	1,048	
	DUES & SUBSCRIPTIONS	XIX F	4,860	
	LICENSES & PERMITS	XIX F	1,688	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,162	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	220	39,484
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,701	
	EQUIPMENT REPAIR & MAINTENANCE		17,384	
	OUTSIDE CLERICAL SERVICES		234,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		9,025	
	MESSENGER SERVICE		0	
			0	262,110

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	139,123	
	UNEMPLOYMENT COMPENSATION	XIX D	15,027	
	WORKERS COMPENSATION INSURANCI	XIX D	48,298	
	HOSPITALIZATION INSURANCE	XIX D	46,883	
	EMPLOYEE BENEFITS - OTHER	XIX D	10,333	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	259,664
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,911	2,911
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		14,569	14,569
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		62,047	62,047
27	**OTHER**			
	BAD DEBTS	VI 24	447	
				447

GRAND TOTAL COLUMN 3 OTHER 833,474

GILMAN NURSING PAVILION
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	147,449	PATIENT MEALS	86544
LESS SALES TAX	(1,157)	ADD EMPLOYEE MEALS	14600
NET FOOD	146,292	TOTAL MEALS/YEAR	101144
TOTAL PATIENT CENSUS	28,848	NET FOOD	146292
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	101144
TOTAL PATIENT MEALS	86544	COST PER MEAL	1.45
		TIME EMPLOYEE MEALS	14600
ADD # EMPLOYEE MEALS/DAY	40		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	21170
TOTAL EMPLOYEE MEALS	14600		

Facility Name & ID Number GILMAN NURSING PAVILION #0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			28,591	28,591		28,591	10,087	38,678			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,610	52,610		52,610	1,905	54,515			32
33	Real Estate Taxes			49,061	49,061		49,061	2,060	51,121			33
34	Rent-Facility & Grounds			508,800	508,800		508,800		508,800			34
35	Rent-Equipment & Vehicles			3,451	3,451		3,451	3,438	6,889			35
36	Other (specify):*											36
37	TOTAL Ownership			642,513	642,513		642,513	17,490	660,003			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		102,319	114,634	216,953		216,953	(698)	216,255			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		102,319	168,837	271,156		271,156	(698)	270,458			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,879,580	402,009	1,644,824	3,926,413		3,926,413	(128,229)	3,798,184			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,366	30		9
10	Interest and Other Investment Income	(19)	32		10
11	Discounts, Allowances, Rebates & Refunds	(919)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,157)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(3,210)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(447)	27		24
25	Fund Raising, Advertising and Promotional	(28,267)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(190)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,843)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(102,386)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (102,386)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (128,229)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GILMAN NURSING PAVILION

ID# 0044263

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	EDUCATION & SEMINARS	(190)	23	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(190)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,076)	0	0	0	0	0	0	0	0	0	0	(2,076)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	770	0	0	0	0	0	0	0	0	770	5
6	Maintenance	0	0	2,190	4,299	0	0	0	0	0	0	0	6,489	6
7	Other (specify):*	0	0	0	0	418	0	0	0	0	0	0	418	7
8	**TOTAL General Services**	(2,076)	0	2,960	4,299	418	0	0	0	0	0	0	5,601	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(1,258)	0	0	0	0	0	(1,258)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(1,258)	0	0	0	0	0	(1,258)	16
	C. General Administration													
17	Administrative	0	(28,000)	0	80,445	0	0	0	0	0	0	0	52,445	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	1,601	0	0	0	0	0	0	0	0	1,601	19
20	Fees, Subscriptions & Promotions	(31,477)	0	587	0	0	0	0	0	0	0	0	(30,890)	20
21	Clerical & General Office Expenses	0	(234,000)	31,163	4,729	0	0	0	0	0	0	0	(198,108)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	(190)	0	0	0	0	0	0	0	0	0	0	(190)	23
24	Travel and Seminar	0	0	64	0	0	0	0	0	0	0	0	64	24
25	Other Admin. Staff Transportation	0	0	1,024	0	0	0	0	0	0	0	0	1,024	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,301	0	0	0	0	0	0	0	0	1,301	26
27	Other (specify):*	(447)	0	6,436	0	17,400	0	0	0	0	0	0	23,389	27
28	**TOTAL General Administration**	(32,114)	(262,000)	42,176	85,174	17,400	0	0	0	0	0	0	(149,364)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,190)	(262,000)	45,136	89,473	17,818	(1,258)	0	0	0	0	0	(145,021)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,366	0	1,721	0	0	0	0	0	0	0	0	10,087	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19)	0	1,924	0	0	0	0	0	0	0	0	1,905	32
33	Real Estate Taxes	0	0	2,060	0	0	0	0	0	0	0	0	2,060	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	3,438	0	0	0	0	0	0	0	0	3,438	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	8,347	0	9,143	0	0	0	0	0	0	0	0	17,490	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(698)	0	0	0	0	0	(698)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(698)	0	0	0	0	0	(698)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(25,843)	(262,000)	54,279	89,473	17,818	(1,956)	0	0	0	0	0	(128,229)	45

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	BOOKKEEPING SERVICES	$ 234,000	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (234,000)	1
2	V	17	MANAGEMENT FEE	28,000				(28,000)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 262,000			$	$ * (262,000)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE	100.00%	$ 770	$ 770	15
16	V	6	REPAIR & MAINT.		" " "		2,190	2,190	16
17	V	19	PROFESSIONAL FEES		" " "		1,601	1,601	17
18	V	20	DUES AND SUBSCRIPTION		" " "		587	587	18
19	V	21	CLERICAL & GENERAL		" " "		31,163	31,163	19
20	V	24	SEMINARS AND TRAVEL		" " "		64	64	20
21	V	25	AUTO EXPENSE		" " "		1,024	1,024	21
22	V	26	INSURANCE		" " "		1,301	1,301	22
23	V	27	EMP. BEN. - GEN, ADMIN.		" " "		6,436	6,436	23
24	V	30	DEPRECIATION		" " "		1,721	1,721	24
25	V	32	INTEREST		" " "		1,924	1,924	25
26	V	33	REAL ESTATE TAXES		" " "		2,060	2,060	26
27	V	35	EQUIPMENT RENTAL		" " "		3,438	3,438	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 54,279	$ * 54,279	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 4,299	$ 4,299	15
16	V	17	ADMIN. CMP. - M. MAUER		" " '		11,858	11,858	16
17	V	17	ADMIN. CMP. - M. AARON		" " '		13,260	13,260	17
18	V	17	ADMIN. CMP. - F. AARON		" " '		15,064	15,064	18
19	V	17	ADMIN. CMP. - S. GOLDSTEIN		" " '				19
20	V	17	ADMIN. CMP. - S. KOPLIN		" " '		7,737	7,737	20
21	V	17	ADMIN. CMP. - D. MAGAFAS		" " '		8,162	8,162	21
22	V	17	ADMIN. CMP. - S. LEVY		" " '		11,054	11,054	22
23	V	17	ADMIN. CMP. - HOWARD ALTER		" " '				23
24	V	17	ADMIN. CMP. - NON-OWNER		" " '		13,310	13,310	24
25	V	21	CLERICAL. CMP. - S. AARON		" " '		4,729	4,729	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 89,473	$ * 89,473	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 418	$ 418	15
16	V	27	EMP.BEN. - M. MAUER		" " '		811	811	16
17	V	27	EMP. BEN. - M. AARON		" " '		1,055	1,055	17
18	V	27	EMP. BEN. - F. AARON		" " '		7,199	7,199	18
19	V	27	EMP. BEN. - S. GOLDSTEIN		" " '				19
20	V	27	EMP. BEN. - S. KOPLIN		" " '		2,709	2,709	20
21	V	27	EMP. BEN. - D. MAGAFAS		" " '		661	661	21
22	V	27	EMP. BEN. - S. LEVY		" " '		1,733	1,733	22
23	V	27	EMP. BEN. - H. ALTER		" " '				23
24	V	27	EMP. BEN. - NON-OWNER		" " '		2,184	2,184	24
25	V	27	EMP. BEN. - S. AARON		" " '		1,048	1,048	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 17,818	$ * 17,818	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$	DYNAMIC REHAB CONSULTANTS LLC		$	$	15
16	V	19	PROFESSIONAL FEES		" " "				16
17	V	22	EMPLOYEE BENEFITS		" " "				17
18	V	39	ANCILLARY SERVICES		" " "				18
19	V								19
20	V								20
21	V	10	MEDICAL SUPPLIES	4,313	LINCOLN MEDICAL SUPPLIES INC		3,055	(1,258)	21
22	V	39	ANCILLARY EXPENSE	2,394	" " "		1,696	(698)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,707			$ 4,751	$ * (1,956)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 11,858	17-7	1
2	MAURY AARON		ADMINISTRATIVE					SALARY	13,260	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	15,064	17-7	3
4	STEVE LEVY		ADMINISTRATIVE					SALARY	11,054	17-7	4
5	SUSAN KOPLIN HARAMARAS		ADMINISTRATIVE					SALARY	7,737	17-7	5
6	SHARON AARON		CLERICAL					SALARY	4,729	21-7	6
7	DIANIA MAGAFAS		ADMINISTRATIVE					SALARY	8,162	17-7	7
8	DENNIS NEHMER		MAINTENANCE					SALARY	4,299	6-7	8
9											9
10											10
11											11
12											12
13								TOTAL	$ 76,163		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	413,836	12	$ 11,039	$	28,848	$ 770	1
2	6	REPAIR & MAINT.	" "	413,836	12	31,419		28,848	2,190	2
3	19	PROFESSIONAL FEES	" "	413,836	12	22,969		28,848	1,601	3
4	20	DUES AND SUBSCRIPTION	" "	413,836	12	8,420		28,848	587	4
5	21	CLERICAL & GENERAL	" "	413,836	12	447,045	345,326	28,848	31,163	5
6	24	SEMINARS AND TRAVEL	" "	413,836	12	917		28,848	64	6
7	25	AUTO EXPENSE	" "	413,836	12	14,696		28,848	1,024	7
8	26	INSURANCE	" "	413,836	12	18,661		28,848	1,301	8
9	27	EMP. BEN. - GEN, ADMIN.	" "	413,836	12	92,321		28,848	6,436	9
10	30	DEPRECIATION	" "	413,836	12	24,690		28,848	1,721	10
11	32	INTEREST	" "	413,836	12	27,602		28,848	1,924	11
12	33	REAL ESTATE TAXES	" "	413,836	12	29,555		28,848	2,060	12
13	35	EQUIPMENT RENTAL	" "	413,836	12	49,319		28,848	3,438	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 778,653	$ 345,326		$ 54,279	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD AVG. HOURS	40	12	$ 55,120	$ 55,120	3	$ 4,299	1
2	17	ADMIN. CMP. - M. MAUER	WGHTD AVG. HOURS	40	12	170,000	170,000	3	11,858	2
3	17	ADMIN. CMP. - M. AARON	WGHTD AVG. HOURS	40	12	170,000	170,000	3	13,260	3
4	17	ADMIN. CMP. - F. AARON	WGHTD AVG. HOURS	47	12	88,500	88,500	8	15,064	4
5	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD AVG. HOURS	45	12	24,000	24,000			5
6	17	ADMIN. CMP. - S. KOPLIN	WGHTD AVG. HOURS	40	12	72,485	72,485	4	7,737	6
7	17	ADMIN. CMP. - D. MAGAFAS	WGHTD AVG. HOURS	45	12	104,642	104,642	4	8,162	7
8	17	ADMIN. CMP. - S. LEVY	WGHTD AVG. HOURS	45	12	158,233	158,233	3	11,054	8
9	17	ADMIN. CMP. - H. ALTER	WGHTD AVG. HOURS	40	12	12,000	12,000			9
10	17	ADMIN. CMP. - NON-OWNER	WGHTD AVG. HOURS	45	12	170,636	170,636	4	13,310	10
11	21	ADMIN. CMP. - S. AARON	WGHTD AVG. HOURS	40	12	67,785	67,785	3	4,729	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,093,401	$ 1,093,401		$ 89,473	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D. NEHMER	WGHTD AVG.HOURS	40	12	$ 5,362	$	3	$ 418	1
2	27	EMP. BEN. - M. MAUER	" "	40	12	11,631		3	811	2
3	27	EMP. BEN. - M. AARON	" "	40	12	13,532		3	1,055	3
4	27	EMP. BEN. - F. AARON	" "	47	12	42,295		8	7,199	4
5	27	EMP. BEN. - S. GOLDSTEIN	" "	45	12	33,649				5
6	27	EMP. BEN. - S. KOPLIN	" "	40	12	25,376		4	2,709	6
7	27	EMP. BEN. - D. MAGAFAS	" "	45	12	8,470		4	661	7
8	27	EMP. BEN. - S. LEVY	" "	45	12	24,807		3	1,733	8
9	27	EMP. BEN. - H. ALTER	" "	40	12	1,105				9
10	27	EMP. BEN. - NON-OWNER	" "	45	12	27,997		4	2,184	10
11	27	EMP. BEN. - S. AARON	" "	40	12	15,016		3	1,048	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 209,240	$		$ 17,818	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION							2
3	19	PROFESSIONAL FEES	" "							3
4	22	EMPLOYEE BENEFITS	" "							4
5	39	ANCILLARY SERVICES	" "							5
6										6
7										7
8		LINCOLN MEDICAL SUPPLIES								8
9	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			3,055			3,055	9
10	39	ANCILLARY EXPENSE	" "			1,696			1,696	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,751	$		$ 4,751	25

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	BANK FINANCIAL		X	TERM NOTE			$	$ 291,707	01/01/06	7.7500	$ 21,701	1
2												2
3												3
4			X	INSURANCE FINANCING							1,846	4
5	BANK FINANCIAL		X	PURCHASE VAN				6,288			960	5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				85,000	05/23/07	8.2500	8,482	6
7	INTERCOMPANY	X		WORKING CAPITAL				527,600			19,621	7
8	RELATED PARTY										1,924	8
9	TOTAL Facility Related						$	$ 910,595			$ 54,534	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 910,595			$ 54,534	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GILMAN NURSING PAVILION **#** 0044263 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	48,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	48,061	2
3. Under or (over) accrual (line 2 minus line 1).	$	61	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	49,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	49,061	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	41,065	8
	2001	41,449	9
	2002	42,730	10
	2003	45,440	11
	2004	48,061	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GILMAN NURSING PAVILION COUNTY IROQUOIS

FACILITY IDPH LICENSE NUMBER 0044263

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-C-23-07-226-004	NURSING HOME	$ 48,060.94	$ 48,060.94
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,060.94	$ 48,060.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8	RELATED PARTY					793		884	91		8
	Improvement Type**										
9	SECURITY CAMERAS			1999	3,500	90	39	90		596	9
10	AIR SYSTEM IN KITCHEN			1999	1,200	31	39	31		190	10
11	FIRE DOOR			1999	8,757	225	39	225		1,419	11
12	FLOOR TILE, VINYL, WALLPAPER			1999	47,922	1,229	39	1,229		7,567	12
13	BLINDS/CURTAINS			2000	473	68	20	24	(44)	268	13
14	PICKET FENCE IMPROVEMENTS			2000	957	64	20	48	(16)	296	14
15	WALLPAPER/HANDRAILS/BUMPERGUARDS			2000	62,558	2,276	27.5	2,276		13,151	15
16	NURSE STATION			2000	29,619	1,077	27.5	1,077		6,220	16
17	ROOM /COMMON AREA SIGNS			2000	2,761	100	27.5	100		567	17
18	AIR CONSITIONER/COMPRESSOR			2000	5,096	185	27.5	185		1,059	18
19	WINDOW/DOOR			2000	3,011	109	27.5	109		645	19
20	WATER HEATER/ VALVE			2000	2,492	91	27.5	91		522	20
21	SOFFIT/FACIA REPAIR			2000	9,746	354	27.5	354		1,796	21
22	GAS LINE INSTALLATION			2000	3,119	113	27.5	113		664	22
23	WATER HEATERS/WATER SOFTENERS			2001	13,740	500	27.5	500		2,228	23
24	WINDOWS			2001	1,493	54	27.5	54		229	24
25	WALL CABINET			2001	743	27	27.5	27		109	25
26	DOORS			2002	1,823	66	27.5	66		234	26
27	GENERATOR / FAN COIL			2002	1,469	54	27.5	54		189	27
28	SMOKE DETECTOR / FIRE CONTROL PANEL			2002	12,098	440	27.5	440		1,534	28
29	BLINDS			2002	1,246	100	20	62	(38)	186	29
30	SPRINKLER REPAIR			2004	1,020	37	27.5	37		55	30
31	FIRE DOORS & LOCKS			2004	3,488	127	27.5	127		185	31
32	NEW COMPRESSOR IN WALK - IN FREEZER			2004	2,242	81	27.5	81		118	32
33	FRE EQUIPMENT			2005	1,516	25	27.5	25		25	33
34	CONCRETE SIDEWALK			2005	3,638	122	15	122		122	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 225,727	$ 8,438		$ 8,431	$ (7)	$ 40,174	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 170,762	$ 12,308	$ 17,076	$ 4,768	10	$ 83,115	71
72	Current Year Purchases	13,541	2,708	677	(2,031)	10	677	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		153	1,388	1,235			74
75	TOTALS	$ 184,303	$ 15,169	$ 19,141	$ 3,972		$ 83,792	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2001 FORD BUS	2001	$ 51,478	$ 5,930	$ 10,296	$ 4,366	5	$ 46,332	76
77										77
78	RELATED PARTY				775	810	35			78
79										79
80	TOTALS			$ 51,478	$ 6,705	$ 11,106	$ 4,401		$ 46,332	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 461,508	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,312	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 38,678	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,366	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 170,298	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: GILMAN ASSOCIATES

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		99	1/1/99	$ 508,800	20		3
4	Additions							4
5								5
6								6
7	TOTAL		99		$ 508,800 **			7

10. Effective dates of current rental agreement:
Beginning 01/01/1999
Ending 12/31/2016

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: AFTER JULY 1, 2006-$4,702,500 *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 2,580 Description: COPY MACHINE
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	01 HONDA ACCORD LX	$ 390.00	$ 871	17
18					18
19					19
20					20
21	TOTAL		$ 390.00	$ 871	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [X]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [X]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	CNA Competency Tests			500		500
9	TOTALS		$	$ 500	$	$ 500
10	SUM OF line 9, col. 1 and 2	(e)	$ 500			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 8,685	$		$ 8,685	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,460			11,460	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			94,489			94,489	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				90,841		90,841	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	SUPPLIES, LAB, RADIOLOGY Other (specify):	39-2					11,478		11,478	13
14	TOTAL			$		$ 114,634	$ 102,319		$ 216,953	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GILMAN NURSING PAVILION **#** 0044263 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (10,716)	635,603		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,518		6
7	Other Prepaid Expenses	7,854		7
8	Accounts Receivable (owners or related parties)	52,200		8
9	Other(specify): RE TAX & INS ESCROW	99,242		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 830,417	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	225,728		15
16	Equipment, at Historical Cost	235,781		16
17	Accumulated Depreciation (book methods)	(244,450)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spc DEPOSITS	238,577		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 455,636	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,286,053	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 236,965	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	910,595		29
30	Accrued Salaries Payable	188,047		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,197		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,000		32
33	Accrued Interest Payable	3,801		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,398,605	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,398,605	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (112,552)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,286,053	$	48

***(See instructions.)**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (38,725)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (38,725)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(73,827)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (73,827)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (112,552)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,728,967	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,728,967	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	122,681	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 122,681	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS EARNED	919	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 919	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,852,586	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	698,007	31
32	Health Care	1,487,888	32
33	General Administration	826,849	33
	B. Capital Expense		
34	Ownership	642,513	34
	C. Ancillary Expense		
35	Special Cost Centers	216,953	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,926,413	40
41	**Income before Income Taxes (line 30 minus line 40)****	(73,827)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (73,827)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,942	2,237	$ 65,949	$ 29.48	1
2	Assistant Director of Nursing	2,185	2,349	55,700	23.71	2
3	Registered Nurses	4,589	5,138	126,897	24.70	3
4	Licensed Practical Nurses	21,047	23,560	449,721	19.09	4
5	CNAs & Orderlies	45,990	50,469	517,037	10.24	5
6	CNA Trainees					6
7	Licensed Therapist	2,103	2,248	59,914	26.65	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,135	2,412	34,595	14.34	9
10	Activity Assistants	5,146	5,730	60,397	10.54	10
11	Social Service Workers	2,329	2,536	49,974	19.71	11
12	Dietician					12
13	Food Service Supervisor	1,835	2,203	30,608	13.89	13
14	Head Cook	7,535	8,285	65,655	7.92	14
15	Cook Helpers/Assistants	9,556	10,157	80,641	7.94	15
16	Dishwashers					16
17	Maintenance Workers	2,205	2,396	30,177	12.59	17
18	Housekeepers	10,299	11,910	117,795	9.89	18
19	Laundry	3,084	3,352	27,200	8.11	19
20	Administrator	1,865	2,204	72,869	33.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,411	2,617	32,661	12.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	208	205	1,790	8.73	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	126,464	140,008	$ 1,879,580 *	$ 13.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	130	$ 5,280	1-3	35
36	Medical Director		1,200	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		4,020	10-3	39
40	Physical Therapy Consultant		1,969	10a-3	40
41	Occupational Therapy Consultant		405	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		15	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	23	1,464	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	153	$ 14,353		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JUDITH PREE	ADMIN		$ 72,869
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,869

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 28,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 28,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KRUPNICK BOKOR	ACCOUNTING	$ 14,500
FROST RUTTENBERG	ACCOUNTING	4,015
OSTROW REISIN BERK	ACCOUNTING	1,724
SACHNOFF & WEAVER	LEGAL FEES	1,453
MYERS, MILLER & KRAUSKOFF	LEGAL FEES	651
LARRY D.SERENE	LEGAL FEES	3,500
PERSONNEL PLANNERS	UC CONSULTANTS	889
ECONOCARE	PURCHASE CONSULTANT	1,813
MANPOWER	OUTSIDE CLERICAL	3,812
HDSI	DATA PROCESSING	2,443
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,800

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,298
Unemployment Compensation Insurance	15,027
FICA Taxes	139,123
Employee Health Insurance	46,883
Employee Meals	21,170
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	10,333
TOTAL (agree to Schedule V, line 22, col.8)	$ 280,834

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 290
Advertising: Employee Recruitment	1,239
Health Care Worker Background Check	220
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	28,267
TRUST/FRANCHISE/CONTRIB/ETC	3,210
LICENSES & PERMITS	1,398
DUES & SUBSCRIPTIONS	4,860
MGMT CO ALLOCATION	587
TRUST/FRANCHISE/CONTRIB/ETC	(3,210)
Less: Public Relations Expense	(0)
Non-allowable advertising	(28,267)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,594

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	64
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 64

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GILMAN NURSING PAVILION # 0044263 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE - $4,191**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES - $2,162**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,695** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,170** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees